Introduction

The California Department of Health Services (CDHS) is pleased to announce the availability of federal funds to expand health care coverage. CDHS is soliciting applications from a county, a city and county, a consortium of more than one county, or a health authority that wishes to develop and implement a health care coverage program.

Each selected applicant will be required to enter into a contract with CDHS prior to being reimbursed for expenditures for health care coverage programs implemented under the Health Care Coverage Initiative (Coverage Initiative). The contract will include, but not be limited to, specific details of the health care coverage program and reimbursement of expenditures to selected applicants.

This Request for Applications (RFA), including any part of the process described in this document for selecting applicants' health care coverage programs and determining the allocations, and any agreements entered into with a county, a city and county, a consortium of counties, or a health authority, is not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. (Welfare & Institutions Code §15907, subdivision (e).)

Requirements, processes, and procedures set forth in this RFA do not constitute incorporation or affirmation of either the provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation. Likewise, use of certain provisions and terminology in this RFA is for administrative convenience only and does not, by that use, constitute adoption or incorporation of any provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation.

Background

In August 2005, the federal Centers for Medicare & Medicaid Services (CMS) approved California's five-year section 1115 *Medi-Cal Hospital/Uninsured Care Demonstration* (Demonstration) (No. 11-W-00193/9). The Demonstration provides $180 million in federal funds in years three, four and five of the Demonstration for the development and implementation of the Coverage Initiative, if the State meets the requirements set forth by CMS.

Senate Bill (SB)1448 (Stats. 2006, Ch. 76) was subsequently enacted to provide the statutory framework for the development and implementation of the Coverage Initiative by adding Part 3.5 (commencing with section 15900) to Division 9 of the Welfare and Institutions Code. Implementation of the Coverage Initiative is subject to the availability of an annual federal allocation of $180 million referenced above. The provisions of SB 1448 are incorporated by reference into this document.

Funding Purpose

The federal funding available under the Coverage Initiative may only be used to expand health care coverage to persons in accordance with the requirements of SB 1448 and the Special Terms and Conditions (STCs) of the Demonstration.

Funding is available for health care services only. Funding cannot be used for administrative costs, which include, but are not limited to, promotion and marketing of the Coverage Initiative in the community, administrative costs associated with the development and management of the health care coverage programs[1] and enrollment of eligible persons.

SB 1448 requires that expansion of health care coverage for eligible low-income, uninsured individuals cannot diminish access to health care available for other low-income, uninsured individuals, including access through disproportionate share hospitals, county clinics, or community clinics. Health care coverage programs funded under the Coverage Initiative are not considered "entitlement" programs.

Definitions

For the purpose of this RFA the following definitions shall apply:

1. "Allocation" means the identification of a portion of the available federal funding for the selected applicants. "Allocation" does not mean a grant or a payment from the State.

2. "Applicant" means a governmental entity that is a county, a city and county, a consortium of counties serving a region consisting of more than one county, or a health authority that applies for Coverage Initiative funds.

3. "Eligible person" means a person who is to be served by the health care coverage programs funded under the Coverage Initiative who is low-income, uninsured and at the time eligibility is determined, is not eligible for the Medi-Cal program, the Healthy Families program, or the Access for Infants and Mothers program.

4. "Health Authority" means a separate public agency established by the Board of Supervisors of a county (or city and county) pursuant to State law, and that has the authority and scope of services available to participate in the Coverage Initiative.

5. "Medical home" means a single provider or facility that maintains all of an eligible person's medical information.

[1] Applicants may claim administrative activities under the Medi-Cal Administrative Activities (MAA) program, if qualified (Welfare & Institutions Code § 14132.47).

6. "Program year" means each of the following twelve-month periods:

   a) September 1, 2007, through August 31, 2008.

   b) September 1, 2008, through August 31, 2009.

   c) September 1, 2009, through August 31, 2010.

Eligibility

Eligible Applicants
Only those applicants defined on page two of this RFA may apply for an allocation of federal funding for the Coverage Initiative.

Eligible Persons
Only those persons defined on page two of this RFA may be served by a health care coverage program funded under the Coverage Initiative.

Coverage Initiative Funding Amount

Federal funds in the amount of $180,000,000 will be available for three consecutive program years to develop and implement health care coverage programs for eligible persons. Funding is limited to the following amounts for each program year of the Coverage Initiative:

1. $180,000,000 for program year September 1, 2007, through August 31, 2008.

2. $180,000,000 for program year September 1, 2008, through August 31, 2009.

3. $180,000,000 for program year September 1, 2009, through August 31, 2010.

Funding Requirements

Allocation/Reallocation Process and Requirements

CDHS will allocate available federal funds to be claimed under the Coverage Initiative to applicants that are selected as a result of the selection process beginning on page 10 of this RFA.

Selected applicants must make expenditures for health care coverage programs according to a schedule that will be determined by CDHS. Prior to the end of the second quarter of each program year, CDHS will request verification of program expenditures to ensure adequate spending levels are met. CDHS intends to make allocations of federal funding for health care coverage programs for the entire three-year period.

If a selected applicant is not meeting CDHS's expenditure schedule in a program year, CDHS may terminate the contract (referred to on page one of this RFA) with the selected applicant. CDHS may redirect the remaining funds to another initially-selected applicant, or to another applicant whose program was not previously selected for funding.

In addition, if a selected applicant fails to substantially comply with any of the terms of the contract, which will comply with CMS's requirements, CDHS may terminate the contract and redirect remaining funds to other selected applicants or to other applicants whose programs were not previously selected for funding, in order to claim all of the annual federal allocation.

Certified Public Expenditures

Selected applicants will be reimbursed solely through the use of the certified public expenditure (CPE) mechanism specified in federal regulations (see 42 C.F.R. 433.51). [2] Each selected applicant must certify its expenditures in accordance with federal guidance for the program as required for CDHS to claim the federal funds made available from the federal allotment. CPEs submitted to CDHS must reflect total funds expenditures for the services provided. Based on the CPEs submitted by each selected applicant, which must be reduced by 17.79 percent, as described below, CDHS will claim federal financial participation (FFP) and pay those amounts to the certifying applicant. The selected applicants are responsible for providing the total funds to be expended; no State General Fund monies will be paid.

The amount that each selected applicant certifies must be reduced by a factor of 17.79 percent to comply with the limitation specified in the STCs of the Demonstration that Safety Net Care Pool funds (the available funds under the Demonstration for uninsured care costs) cannot be claimed for costs associated with the provision of non-emergency services to undocumented immigrants. To implement this limitation, the STCs require that 17.79 percent of each selected applicant's expenditures or claims for services to eligible persons are treated as expended for non-emergency services to undocumented immigrants. Taking into account the 17.79 percent reduction, it is estimated that, in the aggregate, the selected applicants must have expenditures equal to approximately $440 million per year, in order for the State to claim the annual federal allotment of $180 million.

Number of Allocations

At least five applications will be selected to operate health care coverage programs, and no single selected applicant will receive an allocation greater than 30 percent of the total

[2] Although SB 1448 allows the use of IGTs to the extent permitted under the Demonstration, IGTs are not currently permitted under the Demonstration outside of the Disproportionate Share Hospital (DSH) Program.

federal allotment. CDHS will limit the allocation to a selected applicant if the amount requested exceeds 30 percent of the total federal allotment. CDHS is not required to fund the entire amount requested in any one particular application, and may reduce requested allocations to fund additional selected applicants' programs. However, CDHS will not reduce allocations to maximize the number of applications for health care coverage programs that could be funded. Further, CDHS is required by SB 1448 to seek to balance the allocations by selecting programs in different geographic areas of the State.

Use of Funds

Federal funds allocated to selected applicants will supplement, and not supplant, any county, city and county, health authority, State, or federal funds that would otherwise be spent on health care services in that county, city and county, consortium of counties serving a region, or health authority.

Federal funds allocated to selected applicants must reimburse the selected applicants for the benefits and services described in the section entitled "Elements for Evaluation" beginning on page 11 of this RFA.

Federal funds that are available in a particular program year can only be paid for services provided in that particular program year. To the extent that these funds are not claimed for services provided in a given program year, they cannot be paid for expenses incurred for services provided in a later program year.[3] Therefore, it is critical that programs be able to demonstrate that they can begin enrollment no later than September 1, 2007, and that they can submit the necessary documentation of CPEs to substantiate reimbursement in a timely manner.

Enrollment of new eligible persons in a health care coverage program during the last six months of the Coverage Initiative (March 1, 2010, through August 31, 2010) will not be permitted unless CMS approves an extension of the Coverage Initiative.

The total funds expenditure certified by the selected applicants must be from an appropriate source of local funds. The source of funds utilized must not include other federal funds, or impermissible provider taxes or donations, as defined under section 1903(w) of the Social Security Act, and applicable federal regulations.

Timeline

CDHS has established the following timeline for the RFA process.

Event	Due Date	Time

[3] Reimbursement may be made in a subsequent program year for health care coverage program expenditures incurred for services provided in a prior program year.

Event	Due Date	Time
RFA is released to the public	To be determined	
Voluntary pre-application conference in Sacramento	10 days after release of RFA	
Questions about RFA instructions or process to CDHS	3 weeks after release of RFA	
Applications to CDHS	6 weeks after release of RFA	
Oral Interviews (by invitation only)	3 weeks after receipt of applications	
Program selection and allocation notices are posted/issued	1-2 weeks after completion of oral interviews	
Selected applicants begin enrollment of eligible persons	September 1, 2007	

Questions

CDHS requests that prospective applicants notify CDHS if there is a need for clarification regarding the instructions and/or requirements specified in this RFA. Questions can be e-mailed to CDHS at: CoverageInitiative@dhs.ca.gov. CDHS may contact prospective applicants to seek clarification of any issues that may be presented.

Pre-Application Conference

Prospective applicants are encouraged to attend an informational pre-application conference on:

Date:	10 days after release of RFA
Time:	10:00 a.m.
Location:	To be determined

This conference will:

1. Allow prospective applicants to ask questions about submitting an application.

2. Allow prospective applications to ask questions about the requirements for the health care coverage programs.

3. Provide responses to the general questions and issues received before the conference.

While attendance at the conference is recommended, it is not required.

Each prospective applicant should carefully review the entire RFA before the conference to become familiar with the submittal process, eligibility requirements and

elements for evaluation. Prospective applicants are encouraged to have their own copy of this RFA available to refer to during the conference.

If CDHS is unable to respond to all inquiries received before and/or during the conference, written responses will be provided following the conference. CDHS will summarize the general questions and issues that are raised before and during the conference, and provide written responses on the Internet at: http://www.dhs.ca.gov/coverageinitiative.

CDHS will summarize general questions and issues raised and make responses available on the Internet at: http://www.dhs.ca.gov/coverageinitiative. Following the pre-application conference questions must be directed to CDHS by xxx, 2006, at 5:00 p.m. to allow CDHS adequate time to summarize the questions and post them on the Internet. Seven days prior to the due date for applications to be submitted to CDHS, no additional questions will be answered.

Applicants are responsible for their costs to attend the conference. These costs cannot be charged to CDHS, or be included in any cost element of the applicants' proposed budgets.

Reasonable accommodations will be made for individuals with disabilities. CDHS will provide assistive services such as sign language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of pre-application conference handouts (if any), this RFA, questions/answers, RFA addenda, or other administrative notices into Braille, large print, audiocassette, or computer disk. The range of assistive services available may be limited if requestors do not allow ten or more State working days prior to the date that the alternate format material is needed.

To request such services or copies in an alternate format, please contact Ms. Debra Otto at the numbers below, no later than xxx, 2006.

Ms. Debra Otto
Hospital/Uninsured Care Demonstration Section
Direct line: (916) 552-8657
(TTY) California Relay:
1-711-735-2929
1-800-735-2929

Application Format

General Instructions

Each applicant must:

1. Complete applications by following **all** RFA instructions, which may include subsequent clarification issued by CDHS in the form of question and answer notices, clarification notices, or RFA addenda.

2. Seek timely written clarification of any requirements or instructions that the applicant believes to be vague or ambiguous.

3. Limit the application to 25 pages, excluding any attachments and addenda.

4. Arrange for the timely delivery of the application package(s) to one of the addresses specified on page 10 of this RFA.

Format requirements

Each applicant must:

1. Submit an application describing the health care coverage program in the order outlined in the "Elements for Evaluation" beginning on page 12 of this RFA.

2. Format the narrative portion of the application as follows:

   (a) Use one-inch (1") margins at the top, bottom, and both sides.

   (b) Use Arial 12-point font.

   (c) Print pages single-sided on white paper.

   (d) Number each page in the application, including any attachments and addenda.

3. Bind or staple each application set in the upper left-hand corner.

4. Write "Original" on the original application.

5. Ensure that all copies of the application are complete when submitted.

Application Content

Applications submitted to CDHS must include complete and thorough responses to each of the eleven elements for evaluation described in the section entitled "Elements

for Evaluation" beginning on page 12 of this RFA, budget display and additional requirements described below.

Budget Display

The application must contain budget information as described below:

1. Complete the Budget Form available for downloading on CDHS's Internet page at: http://www.dhs.ca.gov/coverageinitiative.

2. Project estimated total expenditures, not just the non-federal share of the expenditures, to provide program services for the entire three-year period.

3. Provide specific expenditure breakdowns for the budget line items.

4. Multiply and total all unit rates/expenses (e.g., unit cost per patient served, expenses to develop a new system/change an existing system, or the expenses associated with health related publications, etc.) for each program year.

5. Report expenditures using whole dollars only by rounding fractional dollar amounts or cents to the nearest whole dollar amount.

6. Enter a total annual expenditure for the stated program year. Ensure that all itemized expenditures equal this figure when added together.

    Note: The Budget Form is not intended to limit the specific expenditures that can be claimed for reimbursement, but is intended to show budgeted expenses in the required format. Use as many pages as necessary to display budgeted expenses for the term specified. Use of computerized reproductions or images is permissible.

Additional Requirements

The application must include the following items:

1. Identification of the geographic area that the program will serve.

2. A list of the network of health care providers who have agreed to participate and provide services to the target population.

3. An explanation of the source of the funds to be used by the applicant to fund the proposed healthcare coverage program.

4. A consent form signed by the applicant to provide requested data elements as required in the STCs of the Demonstration. An example is available on CDHS's Internet page at: http://www.dhs.ca.gov/coverageinitiative.

Application Submission

Please note that if the applicant is a consortium of counties serving a region consisting of more than one county, the consortium of counties must designate one county as the applicant to be responsible for completing and submitting the application.

Each applicant must:

1. Submit its application in hard copy. No electronic media will be accepted.

2. Sign the application and any attachments and addenda in blue ink. The application must be signed by an individual with authority to agree to perform the activities on behalf of the applicant.

3. Prepare an original and five (5) copies of the application. Place the application set marked "Original" on top, followed by the five (5) extra copies.

   (a) Place all originally signed documents in the application marked "Original."

   (b) The five extra copies of the application may reflect photocopied signatures.

4. Place the original and five (5) copies in a single envelope or package, if possible.

5. Label each envelope or package, if submitting more than one envelope or package.

6. Ensure applications are postmarked by xxx, 2006, or hand delivered to CDHS by 5:00 p.m. on xxx, 2006.

7. Submit applications using one of the following options:

Hand Delivery or Overnight Express	U.S. Mail
Coverage Initiative Application CA Dept. of Health Services Medi-Cal Operations Division Attention: Debra Otto 1501 Capitol Avenue, Suite 71.3002, MS 4506 Sacramento, CA 95814	**Coverage Initiative Application** CA Dept. of Health Services Medi-Cal Operations Division Attention: Debra Otto 1501 Capitol Avenue, MS 4506 P.O. Box 997419 Sacramento, CA 95899-7419

If the hand delivery option is chosen, please allow adequate time to locate parking and to wait at the security desk on the street level until a CDHS staff member receives the application. Upon arrival in the building, inform the security personnel that you have a delivery for Ms. Debra Otto, at telephone number: (916) 552-8657.

Applicants are responsible for all costs of developing and submitting an application. These costs cannot be charged to CDHS or be included in any cost specified in the applicant's proposed budget.

Application Evaluation

Each application received by CDHS that is timely and meets basic format requirements will be submitted to an evaluation committee with the requisite background and experience to enable the committee to select applicants with the best qualified proposed health care coverage programs. Any application that does not include the documentation as required in the section entitled "Application Content" beginning on page 8 of this RFA will not be further evaluated.

There are three review processes that will be used to determine the allocation of the available federal funds to prospective applicants: pass-fail review, technical review and secondary review.

A "pass" or "fail" rating will be applied to each element. Any application that receives one "fail" rating, on any required element, will be eliminated from the application review process.

Those applications that receive a "pass" for all of the eleven elements will advance to the technical review process as described on page 15 of this RFA. The evaluation committee will assign points to the responses for each of the eleven elements set forth in the "Elements for Evaluation," the scoring to be based on the likelihood of achieving the required outcomes as described below.

The secondary review, which will result in the actual selection of the applicants, is described at pages 15 through 16 of this RFA.

Required Outcomes

In evaluating the responses to each of the eleven evaluation criteria, the evaluation committee will assign points based on how well each response, when implemented, would contribute to achieving the following outcomes, as applicable:

1. Expand the number of Californians who have health care coverage.

2. Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics.

3. Improve access to high quality health care and health outcomes for individuals.

4. Create efficiencies in the delivery of health care services that could lead to savings in health care costs.

5. Provide grounds for long-term sustainability of the programs funded under the Coverage Initiative beyond August 31, 2010, when the annual federal allocation for the Coverage Initiative ends.

6. Implement programs in an expeditious manner in order to meet federal requirements regarding the timing of expenditures.

Elements for Evaluation

All of the following elements will be evaluated and scored using the five-point scale as described on page 15 of this RFA:

1. Enrollment processes, with an identification system to demonstrate enrollment of eligible persons into the proposed health care coverage program.

   Each application must include:

   (a) A description and estimated number of eligible persons to be served annually.

   (b) A description of the process and/or source of data for identifying the estimated number of eligible persons to be served.

   (c) An explanation of the applicant's ability to ensure optimal enrollment levels is maintained.

2. Use of a medical records system, which may include electronic medical records.

   Each application must include:

   (a) A description of the reliable medical record system to be used that may include, but need not be limited to, existing electronic medical records, including a description of the safeguards utilized to comply with the Health Information Portability and Accountability Act (HIPAA).

   (b) A description of the unique identifiers that are assigned to each eligible person receiving health care services.

   (c) A description of the method used to track and record services provided to eligible persons.

   (d) A description of processes and controls to identify and reduce medical errors and eliminate duplicate services.

3. Designation of a medical home and assignment of eligible persons to a primary care provider, which is a provider from which the eligible person can access primary and preventive care.

Each application must include:

(a) A description of the organized health care delivery system(s) to be used for the health care coverage program, including but not limited to, designation of a medical home and processes used to assign eligible persons to a primary care provider.

(b) Identification of the designated medical home and its relationship with the health care coverage program.

(c) A description of relationships, such as partnerships, collaborations, or arrangements with other health care providers in the community; how those relationships will ensure effective delivery of services; and the applicant's ability to effectively coordinate, manage, and monitor the delivery of services.

(d) A description of processes to ensure that health care services match the needs of the target population.

4. A description of services to be included in a benefit package, particularly preventive and primary care services, as well as care management services designed to treat individuals with chronic health care conditions, mental illness, or who have high costs associated with their medical conditions in order to improve their health and decrease future costs. Benefits may include case management services.

   Each application must include:

   (a) A description of the care management services to be provided and the providers of those services.

   (b) A list of the health benefits to be provided, including the primary care and preventive care services, and how the services will be promoted in the community, and an estimate of the average cost per eligible person to be served.

   (c) A description of the system(s) and/or procedure(s) for case management and care management that demonstrates that there is sufficient capacity to ensure access and optimal utilization, and an estimate of the average cost per eligible persons to be served.

   (d) A description of the applicant's processes for conducting periodic utilization reviews for case management and care management to evaluate whether the services provided are consistent with program utilization projections (on a concurrent and retrospective basis).

(e) A description of the processes that will be used to evaluate whether the health care provider locations for case management and care management meet the needs of the target population and provide adequate access.

5. Quality monitoring processes to assess the health care outcomes of the eligible person enrolled in the health care coverage program.

   Each application must include:

   (a) A description of the quality monitoring system and demonstrate that the system is technically sound with sufficient capacity to be implemented with the health care coverage program.

   (b) A description of system processes to effectively coordinate, manage, and monitor services to ensure the quality of care.

   (c) An explanation of what standards will be used to quantify, measure, and report on the quality of care.

   (d) A description of the method by which the applicant will ensure that subcontractors have the capability to effectively establish, coordinate, manage, monitor, and maintain quality efforts.

6. Promotion of the use of preventive services and early intervention.

7. The provision of care to Medi-Cal beneficiaries by the applicant and the degree to which the applicant coordinates its care in the proposed program with services provided to Medi-Cal beneficiaries.

8. A description of the screening and enrollment processes for individuals who may qualify for enrollment into the Medi-Cal, Healthy Families, or the Access for Infants and Mothers programs prior to determining eligibility and enrollment into the health care coverage program.

9. The ability to demonstrate how the health care coverage program will promote the viability of the existing safety net health care system.

10. Documentation to support the applicant's ability to implement the health care coverage program by September 1, 2007, and to use its allocation for each program year.

11. An explanation of how the health care coverage program will offer consumer assistance to individuals applying to, participating in, or accessing services in the program.

Review Process

Pass-Fail Review

A "pass" or "fail" rating will be applied to each of the eleven elements. Any application that receives one "fail" rating, on any required element, will be eliminated from the application review process.

Technical Review

The evaluation committee will assign points to the responses for each of the eleven elements set forth in the "Elements for Evaluation," the scoring to be based on the likelihood of achieving the required outcomes as described at pages 11 and 12 of this RFA. The review will result in a score for each application based on its technical merit.

Each element for evaluation will be scored using a five-point scale. The five-point scale will consist of the following ratings:

4 points	=	Excellent
3 points	=	Very Good
2 points	=	Good
1 point	=	Poor
0 points	=	Inadequate

The maximum possible total for Items 1 through 11 is 44 points. The fact that an application receives a high number of points is not a guarantee of funding.

Secondary Review and Analysis

The number of points an application receives from the technical review will be the basis for further consideration of an allocation. Based on the number of points, and the result of the secondary review and analysis, CDHS will determine the final ranking of the applications.

In making the final ranking of the applications, the evaluation committee will also consider if the application, taken as a whole:

1. Is fully developed, with few, if any, weaknesses, defects, or deficiencies, and does not lack depth, breadth, or significant facts or information.

2. Demonstrates the applicant's capacity, capability and/or commitment to meet or exceed program requirements (e.g., enhanced features, approaches, or methods, and/or creative or innovative solutions).

3. Demonstrates that the applicant would be efficient in operating and administering a program based on the cost per patient in proportion to the total number to be served.

Within each of the geographic areas listed below, the evaluation committee will array the applications from the highest to the lowest ranking, and select the highest ranking application within each of the following three areas.

1. The Greater Bay Area (including Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma Counties).

2. Southern California (including Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties).

3. The remaining area of the State, not listed in 1 and 2, above.

Following selection of the three applications from the areas listed above, the evaluation committee will array the remaining applications from the highest to the lowest ranking and select two or more applications with the highest ranking(s) statewide.

Final selection and allocation decisions are subject to the availability of funds and may differ from the amount requested in the applications. CDHS may reject any application or any proposed component of a health care coverage program.

Final selections for funding will take into account the geographic distribution of health care coverage programs. CDHS will seek to balance the distribution of funds geographically.

Oral Interview

The evaluation committee may, at its sole discretion, conduct interviews with some or all of the applicants in order to better assess and/or confirm the information presented in the application, including but not limited to, the following:

1. The committee's understanding of the applicant's responses to the RFA.

2. The applicant's understanding of the requirements and the significance of the Coverage Initiative.

3. The applicant's commitment to provide quality services within the established timeframe.

4. The capabilities and strengths of the applicant's infrastructure.

5. The soundness, capacity, and strengths of the applicant's delivery, monitoring, and administrative systems.

Application Withdrawal and Resubmission

1. An applicant may withdraw an application at any time before the submission deadline by submitting a written withdrawal request signed by the applicant's authorized representative. All withdrawal requests must be submitted using one of the submission and delivery options specified on page 10 of this RFA.

2. An applicant may resubmit a new application according to the application submission instructions. Resubmitted applications must be received by xxx, 2006, by 5:00 p.m. using one of the delivery options specified on page 10 of this RFA.

3. CDHS requests that applicants confirm with Ms. Debra Otto at (916) 552-8657 that the withdrawal request was received.

Disposition of Applications

1. All materials submitted in response to this RFA will become the property of CDHS and become subject to the Public Records Act (Government Code Section 6250 et seq.) once program selection and allocation notices are posted. Therefore, CDHS requests that applicants do not submit any information with the application that the applicant considers confidential or proprietary.

2. Application contents, applicant correspondence, evaluation committee working papers and any other part of the application process will be held in the strictest confidence until the program selection and allocation notices are issued.

No Further Proceedings

All processes and procedures set forth in this RFA constitute the sole administrative processes and procedures available for applicants. No further administrative remedies (e.g., protests, appeals, or requests for reconsideration) will be available for applicants following CDHS's issuance of its decision concerning selected applications and allocations made available pursuant to SB 1448, the requirements of the STCs of the Demonstration, and this RFA.